STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

Raul Pino, M.D., M.P.H.
Commissioner

Dannel P. Malloy
Governor

Nancy Wyman
Lt. Governor

Healthcare Quality And Safety Branch

August 7, 2018

John Murphy, Administrator
Danbury Hospital
24 Hospital Avenue
Danbury, CT 06810

Dear Mr. Murphy:

Unannounced visits were made to Danbury Hospital on July 10, 11 and 12, 2018 by a representative of the Facility Licensing and Investigations Section of the Department of Public Health for the purpose of conducting an investigation.

Attached are the violations of the Regulations of Connecticut State Agencies and/or General Statutes of Connecticut which were noted during the course of the visits.

You may wish to dispute the violations and you may be provided with the opportunity to be heard. If the violations are not responded to by August 21, 2018 or if a request for a meeting is not made by the stipulated date, the violations shall be deemed admitted.

Please prepare a written Plan of Correction for the above mentioned violations to be presented at this conference.

Each violation must be addressed with a prospective Plan of Correction which includes the following components:

1. Measures to prevent the recurrence of the identified violation, (e.g., policy/procedure, inservice program, repairs, etc.).
2. Date corrective measure will be effected.
3. Identify the staff member, by title, who has been designated the responsibility for monitoring the individual plan of correction submitted for each violation.

A telephone conference has been scheduled for August 24, 2018 at 9AM in regards to the aforementioned violation. Should you wish to retain legal representation, your attorney may accompany you to this meeting. Please call me directly to participate in this conference at 860-509-7436. Should you have any questions, please do not hesitate to contact me.

Respectfully,

Cheryl Davis, RN, BSN
Supervising Nurse Consultant
Facility Licensing and Investigations Section

CAD:mb

The following are violations of the Regulations of Connecticut State Agencies Section 19-13-D3 (b)

DATES OF VISIT: July 10, 11 and 12, 2018

THE FOLLOWING VIOLATION(S) OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

Administration (2) and/or (d) Medical Records (3) and/or (e) Nursing service (1) and/or (i) General (6).

1. Based on medical record reviews, review of facility documentation, review of facility policies and interviews for one of ten patients who had a change in condition (Patient #1), the facility failed to ensure the RN responded to a report of a possible cardiac rhythm change and/or changes noted in breathing/behavior noted by unlicensed personnel resulting in a delay in assessment and physician notification. The finding includes:
   a. Patient #1 was admitted to the hospital on 4/2/18 with sepsis due to cellulitis with gangrene of the left lower extremity and had a past medical history that included cerebral vascular accident (CVA), diabetes and hypertension. Review of the clinical record dated 4/6/18 noted that the patient had a change in condition and a head CT scan identified that the Patient had a small acute infarct (stroke) involving the left occipital lobe. Patient #1 was transferred to 10W (stroke unit) on 4/6/18 at 4:53 PM.
   Review of RN#1's assessment dated 4/6/18 at 12:42 AM identified that the patient was calm, appropriate, drowsy, was unable to determine orientation, had normal heart sounds, a regular heart rhythm, unlabored respirations, no shortness of breath, diminished breath sounds (anterior and posterior), and was on three (3) liters of oxygen.
   The record dated 4/7/18 identified that PCT (patient care tech) #1 documented that the Patient was transferred to the chair with two staff at 3:10 AM.
   Review of facility documentation identified that the Patient's heart monitor leads were off on 4/7/18 at 1:22 AM, 1:48 AM, 2:30 AM and 2:53 AM, 3:26 AM and 3:27 AM. The Patient's telemetry box was changed at 2:55 AM.
   The telemetry strips dated 4/7/18 at 1:23 AM identified the patient had a heart rate 71 beats per minute (bpm) with a normal sinus rhythm and had questionable changes in the Patient's rhythm at 2:55 AM and 3:54 AM. In addition, an elevation of the Patient's pulse was noted at 3:54 AM from 72 bpm to 93 bpm and at 4:09 AM, the patient's pulse was 29 bpm.
   Review of RN #1's nurse's note dated 4/7/18 indicated that Patient #1 was found pulseless and unresponsive at 4:05 AM and this coincided with a bradycardic event noted and alert sent by Monitor Technician #1. The cardiac arrest code sheet identified that the Patient was resuscitated from 4:12 AM on 4/7/18 to 4:30 AM, had return of spontaneous circulation and was transferred to the ICU. The CT scan dated 4/7/18 noted a left cerebral artery infarct (stroke) affecting the anterior left parietal area and ischemia of the left cerebellum. Patient #1's prognosis was poor and the Patient subsequently expired on 4/7/18 at 1:20 PM.
   Interview with RN #1 on 7/11/18 at 1:10 PM noted that when he began his shift on 4/6/18 at 11:00 PM, Patient #1 was restless, constantly pulling at his leads and trying to get out of the bed. RN #1 indicated that PCT #1 informed him at approximately 3:30 AM on 4/7/18 that the Patient looked sick, he assessed the Patient who "looked good" and the Patient was a little tachycardic at that time. RN #1 further identified that Monitor Tech #1 never informed him of questionable telemetry changes and the only alert he received was when the patient was bradycardic (heart rate of 38 bpm) at 4:02 AM on 4/7/18 and around the same time, the red phone rang on the unit as he was headed to the patient's room.
   Interview with Monitor Technician #1 on 7/12/18 at 9:52 AM identified that she was sending text messages back and forth to RN #1 and PCT #1 about leads being off or cable disconnected from the cardiac monitor. Monitor Technician #1 stated she spoke to RN #1

and PCT #1 about lead attachment as she was unable to see the rhythm at one point. Monitor Technician #1 stated she called PCT #1 to check leads because the patient's rhythm looked different, however, PCT #1 was on break so another PCT checked the patient and the telemetry was changed. After the telemetry was changed, Monitor Technician #1 stated she called RN #1 to check the leads, however, never received a return call despite calling a few times and a little while after that, she called the red phone on the unit when a low heart rate was identified. Monitor Technician #1 did not provide a specific timeline of the events.

Interview with PCT #1 on 7/11/18 at 1:36 PM noted that Patient #1 was calm at the beginning of her shift at 11:00 PM on 4/6/18, and became restless and RN #1 was notified who told PCT #1, the patient "is ok, just a little short of breath". PCT #1 further identified that the patient became increasingly restless and the patient was assisted to the chair, however continued to be restless and short of breath. PCT #1 stated she informed RN #1 that something was wrong and she suggested that RN #1 call RT (respiratory therapist). RN #1 told PCT #1 that the patient was fine, just short of breath and did not enter the room to evaluate the patient. PCT #1 indicated that she was so worried about Patient #1, that when RN #1 did not help the Patient, She asked RN #2 to help and RN #2 indicated that this was not her patient. When RN #2 didn't respond, PCT #1 yelled out for help and RN #3 came to assist with the patient then a code was called. PCT #1 stated she did not know to notify the charge nurse when RN #1 and RN #2 failed to respond.

Interview with RN #2 on 7/19/18 at 9:11 AM identified that PCT #1 did mention that her "patient was restless and that she (PCT #1) had to keep going in and out of the room. When PCT #1 expressed serious concern for Patient #1, RN #2 got up and asked RN #1 caring for the patient and another nurse on duty, RN #3 that she was informed Patient #1 wasn't doing well and both RN #1 and RN #3 said that Patient #1 was fine. RN #2 stated she went to check Patient #1, who was seated in a Geri chair and had agonal breathing. RN #2 indicated that RN #1 was unsure of the patient's code status, PCT #1 verified that Patient #1 was a full code, and RN #2 directed that a "Code" be called.

Interview with MD #1 on 7/11/18 at 11:54 AM noted that he would expect to be notified if a patient became increasingly restless and would have directed that a 12 lead EKG be performed with any questionable telemetry reading.

Interview with the Quality Specialist on 7/10/18 at 12:37 PM and review of the Patient's record indicated that RN #1 did not document the assessed restless behavior and did not document assessments based on PCT #1's concerns. The Quality Specialist further indicated that RN #1 should have let the provider know when the Patient had a change in condition, believed that Monitor Tech #1 had tried to inform RN #1 of the questionable telemetry changes, and a 12 lead EKG should have been performed. The Quality Specialist further identified that Monitor Tech #1 stated she had called RN #1 a couple times after the telemetry box was changed for questionable telemetry changes but, RN #1 did not pick up the call. The Quality Specialist stated that her interviews with staff during the investigation identified RN #1 was aware of the patient's code status and a code was initiated immediately.

The facility policy for telemetry responsibilities of the RN noted to respond to all calls from the Monitor Technician. The facility policy for scope of service 10 West identified that an interdisciplinary approach is used to provide patient care and the RN is primarily

responsible to manage the patient during his/her shift. The facility RN 1 job description identified a major accountability to perform assessments in an ongoing and systematic manner.